Multiple exclusion homelessness in the UK: an overview of findings

Multiple Exclusion Homelessness in the UK:

An Overview of Key Findings

Briefing Paper No. 1

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Summary

This Briefing Paper examines the characteristics and experiences of people affected by 'multiple exclusion homelessness' (MEH) – a form of 'deep' social exclusion involving not just homelessness but also substance misuse, institutional care (e.g. prison) and/or involvement in 'street culture' activities (e.g. begging and street drinking). It draws upon a quantitative survey conducted amongst users of 'low threshold' homelessness and other services in seven UK cities.

Key points:

- There is a strong overlap between more extreme forms of homelessness and other aspects of deep exclusion, with nearly half of all low threshold service users reporting experience of institutional care, substance misuse and street culture activities, as well as homelessness
- Homelessness is an especially prevalent form of deep exclusion, with its experience reported as widespread amongst those accessing support services focused on other issues, such as drug misuse
- There are five distinct 'experiential clusters' within the MEH population, with the most complex forms of MEH being concentrated amongst men in the middle age range (especially those in their 30s)
- The chronological ordering of MEH-relevant experiences is remarkably consistent within people's life histories, with substance misuse and mental health problems generally preceding experience of homelessness, including rough sleeping, and other adverse life events
- Most MEH service users had experienced troubled childhoods marred by school and/or family problems, with many also reporting traumatic experiences such as sexual or physical abuse, homelessness or neglect. In adulthood, the incidence of self-harm and suicide attempts is notable
- Individuals who had migrated to the UK (as adults) reported less difficult family backgrounds and lower levels of support needs than the rest of the MEH population

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Introduction

There is growing concern in the UK about the need for a more sophisticated understanding of severe and multiple disadvantage – sometimes called 'deep social exclusion' - to inform better responses to people with complex needs (Cabinet Office/Social Exclusion Task Force, 2007; Rosengard *et al.*, 2007; Hampson, 2010). This reflects a heightened awareness that the populations at the sharpest end of problems such as homelessness, substance misuse, poor mental health, and involvement with the criminal justice system are often costly to society as a whole (Clinks *et al*, 2009; Sainsbury Centre for Mental Health, 2009), but at the same time are extremely vulnerable individuals who often 'fall between the gaps' in policy and services (Cornes *et al*, 2011; Revolving Doors Agency & MEAM, 2011).

These concerns prompted the establishment of the Multiple Exclusion Homelessness Research Programme, which funded four research projects, and ran from 2009 to 2011 (see McDonagh, 2011). This Briefing Paper provides an overview of the key findings from the quantitative study funded under this programme, which sought to provide a statistically robust account of the nature and patterns of multiple exclusion homelessness (MEH) across the UK. MEH was defined in this study as follows:

> People have experienced MEH if they have been *'homeless'* (including experience of temporary/unsuitable accommodation as well as sleeping rough) *and* have also experienced one or more of the following other domains of 'deep social exclusion': *'institutional care'* (prison, local authority care, mental health hospitals or wards); *'substance misuse'* (drug, alcohol, solvent or gas misuse); or participation in *'street culture activities'* (begging, street drinking, 'survival' shoplifting or sex work).

In order to generate a statistically representative sample of people experiencing MEH, a multi-stage research design was adopted in the following urban locations where existing information suggested people experiencing MEH were concentrated: Belfast; Birmingham; Bristol; Cardiff; Glasgow; Leeds; and Westminster (London).

The study involved three main stages:

- Selection of a random sample of six 'low-threshold'[1] services working with people experiencing deep social exclusion in each location[2], including not only homelessness services but also those targeting other aspects of deep exclusion, e.g. drug problems, alcohol problems, street-based sex work etc.
- A *Census Questionnaire Survey* was then conducted with all of the users of these low-threshold services over a two-week 'time window'. 1,286 questionnaires were returned in total.
- Finally, an *Extended Interview Survey* was conducted with a sample of users of low threshold services whose census responses indicated that they had experienced MEH. These interviews were conducted face-to-face and lasted 46 minutes on average. Particularly sensitive questions were asked in a self-completion section. In total, 452 extended interviews were achieved.

The analysis presented here has been weighted to take account of disproportionate sampling and non-response bias so that the survey estimates provided are as robust as possible.

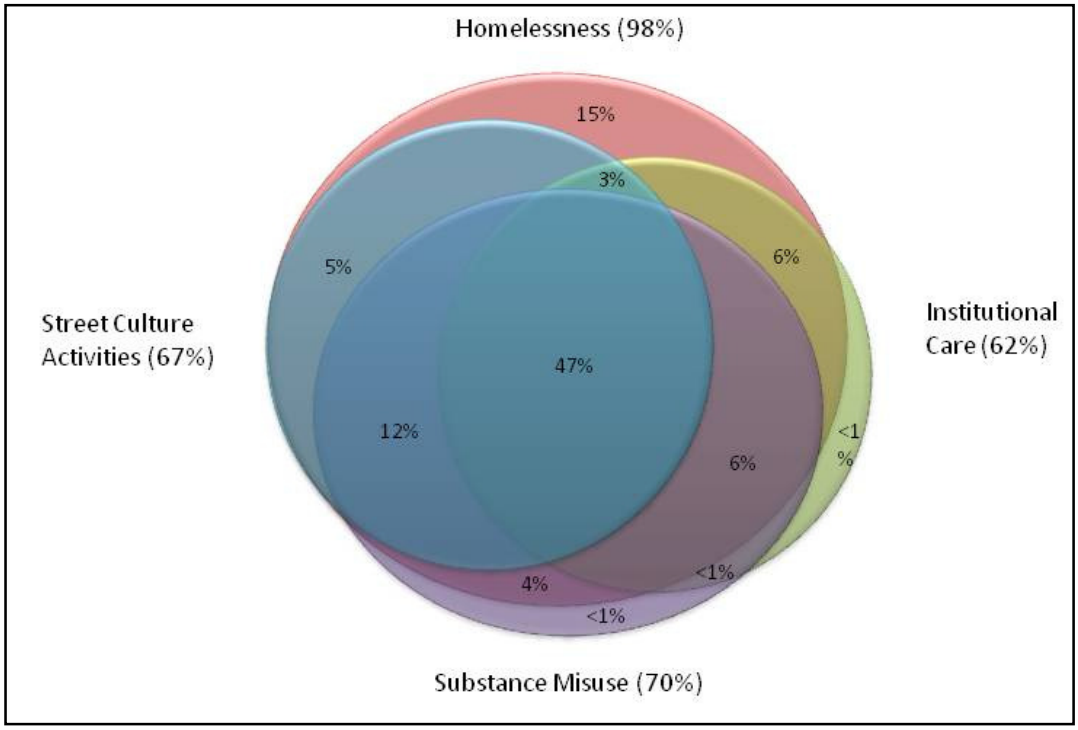
[1] 'Low-threshold' services are those that make relatively few 'demands' of service users, such as day centres, soup runs, direct access accommodation, street outreach teams, drop-in services, needle exchanges, etc.

[2] Leeds was a half-size pilot study prior to the main-stage fieldwork, so only three services were selected there. A total of 39 services participated in the study overall.

Key Findings from Census Questionnaire Survey

The Census Questionnaire Survey of low-threshold service users demonstrated that experience of each of the specified domains of deep social exclusion was extremely widespread amongst this population (see also Fitzpatrick *et al*, 2011). Almost all (98%) had experienced homelessness, 70% had experienced substance misuse, 67% street culture activities, and 62% institutional care (Figure 1). Consequently, the degree of overlap between these domains was also very high, with almost half (47%) of service users having experienced all four domains.

Figure 1: Overlap between domains of deep social exclusion



Source: Census Questionnaire Survey, 2010. Base: 1,286.

The Census Questionnaire Survey also demonstrated that homelessness was a particularly prevalent form of exclusion, with its experience reported as widespread amongst those accessing services aimed at other dimensions of deep exclusion, such as drug misuse. In fact, while service users recruited from these 'other services' were somewhat less likely to have slept rough than those recruited from homelessness services, they were just as likely to have stayed in a hostel or other temporary accommodation, and were actually more likely to have stayed with friends or relatives because they had no home of their own or to have applied to the council as homeless (Table 1 overleaf).

Table 1: Experience of homelessness, by type of service

Indicator	Homelessness Service	Other Service	All
1. Stayed with friends, relatives or other people because had no home of own	78%	87%	80%
2. Stayed in a hostel, foyer, refuge, night shelter or B&B hotel because had no home of own	83%	82%	83%
3. Slept rough	80%	69%	78%
4. Applied to the council as homeless	70%	84%	73%
Base	**1,112**	**174**	**1,286**

Source: Census Questionnaire Survey, 2010

Key Findings from Extended Interview Survey

The main phase of the study used an Extended Interview Survey to explore in detail the prevalence, complexity, clustering and sequencing of MEH-relevant experiences in adulthood, as well as childhood experiences of disadvantage and trauma amongst MEH service users (see also Fitzpatrick *et al*, under review (a)). The MEH service users interviewed were predominantly male (78%), and were concentrated in the middle age ranges (approximately half were 30-49 years old).

The prevalence and complexity of MEH experiences

Table 2 (overleaf) presents the overall reported prevalence of specific MEH-relevant experiences. Some of these 28 experiences were selected as specific indicators of the 'domains of MEH' identified above (i.e. homelessness, substance misuse, institutional care, and street culture activities), whereas others are 'adverse life events' that qualitative research has indicated may trigger homelessness and related forms of exclusion (Crane *et al*, 2005; Fitzpatrick *et al*, 2009; Jones & Pleace, 2010). A number of indicators of 'extreme exclusion or distress' are also included.

As Table 2 indicates, all of the specified forms of homelessness were reported by around three-quarters or more of MEH service users. Almost two-thirds of MEH service users reported alcohol problems, with experience of hard drugs[3] noted by approaching half of all interviewees. Prison was by far the most common form of institutional care experienced, though the level of admission to hospital with a mental health issue was also strikingly high. Over half of MEH service users had been involved in street drinking, and survival shoplifting and begging were also common forms of street culture activity. The most widely reported adverse life events were breakdowns in relationships with parents or partners. Experience of anxiety and depression was extremely widespread, and almost four in ten MEH service users reported having attempted suicide at least once, with approaching one-third having engaged in deliberate self-harm. Being a victim of violent crime was reported by a large minority of respondents, and one quarter admitted to having themselves been charged with a violent criminal offence.

[3] A list of 'hard drugs' was not specified in this question because drugs markets differ across the UK, as do 'street names' for drugs, and any attempt to be comprehensive would have led to a question that was far too long and complex. We did, however, ask a follow up question on definitions of hard drugs and this confirmed that virtually all respondents understood this term (as intended) to denote drugs such as heroin, cocaine and crack cocaine, and did not include 'soft' or 'recreational' drugs such as cannabis or ecstasy.

Table 2: MEH-relevant experiences

	Percent
Homelessness	
Stayed at a hostel, foyer, refuge, night shelter or B&B hotel	84%
Stayed with friends or relatives because had no home of own ('sofa-surfed')	77%
Slept rough	77%
Applied to the council as homeless	72%
Substance misuse	
Had a period in life when had six or more alcoholic drinks on a daily basis	63%
Used hard drugs	44%
Injected drugs	27%
Abused solvents, gas or glue	23%
Institutional care	
Went to prison	46%
Admitted to hospital because of a mental health issue	29%
Left local authority care	16%
Street culture activities	
Involved in street drinking	53%
Shoplifted because needed things like food, drugs, alcohol or money for somewhere to stay	38%
Begged (that is, asked passers-by for money in the street or another public place)	32%
Had sex or engaged in sex act in exchange for money, food, drugs or somewhere to stay*	10%
Adverse life events	
Divorced or separated from a long-term partner	44%
Thrown out by parents/carers	36%
Evicted from a rented property	25%
Made redundant	23%
A long-term partner died	10%
Home was repossessed	6%
Experienced bankruptcy	6%
Extreme exclusion/distress	
Had a period in life when very anxious or depressed	79%
Were a victim of violent crime (including domestic violence)	43%
Attempted suicide*	38%
Deliberately self-harmed*	30%
Charged with a violent criminal offence*	27%
Victim of sexual assault as an adult*	14%
Base	**452**

Source: Extended Interview Survey, 2010. * Asked in self-completion section

Regression analysis was used to investigate which social and economic background factors had an *independent effect* in predicting the most and least 'complex' experiences of MEH, as measured by the number of these specific MEH-relevant experiences reported. This analysis does not predict the likelihood of a member of the general public experiencing MEH, but rather asks: amongst members of the MEH population, what predicts whether they have had a more or less complex set of MEH experiences?

Factors associated with *more* complex MEH experiences, other things being equal, included:

- being male;
- being aged between 20 and 49 years old (especially in 30s);

- having experienced any of the following as a child: physical abuse or neglect, there sometimes not being enough to eat at home, or homelessness;
- having parents with problems such as domestic violence, substance misuse or mental health issues;
- having had poor experiences of school (i.e. truancy, exclusion, victim of bullying);
- being brought up in a household with at least one adult in paid work all or most of the time;
- having lived on welfare benefits for most of your adult life;
- being recruited to the study from a 'non-homelessness' service.

Perhaps the most surprising finding on this list is the association between being brought up in a 'working' household and the more extreme forms of MEH (but see also Ray *et al*, 2010). The association between recruitment from a 'non-homelessness' service and more complex forms of MEH is consistent with the interrelationship between extreme complexity and hard drug use that also emerged from cluster analysis (see below), as most of these non-homelessness low-threshold services were aimed at drug users.

Factors associated with *less* complex MEH experiences, other things being equal, included:

- being female;
- being young (under 20) or older (over 50);
- being a migrant to the UK;
- being a Westminster (London) respondent;
- being in steady work for most of your adult life;
- being recruited to the study from a homelessness service.

Many of the factors on this list are the converse of the factors associated with the more complex forms of MEH. The finding on migrants seems likely to reflect the restricted access to welfare benefits of many migrant groups in the UK, which may mean that they are at risk of MEH from a lower 'threshold' of personal support needs than is the case for other sections of the population (see Briefing Paper No 2 in this series; Fitzpatrick *et al*, under review (b)). The association between recruitment in Westminster and lower levels of complexity seems most likely to be explained by the particularly strong in-flow of 'new rough sleepers' in this locality, as this group tend to report lower levels of support needs than the more 'entrenched' rough sleepers who are (proportionately) dominant elsewhere (Broadway, 2011).

Clustering of MEH experiences

Statistical clustering techniques were employed to investigate whether there were particular subgroups within the MEH population with similar sets of experiences. This resulted in the following set of five clusters.

Cluster 1: 'Mainly homelessness' This cluster accounted for one quarter of MEH service users (24%) and was the least complex overall (5 experiences on average). Cluster 1 cases were less likely than the MEH population as a whole to report experiences within the non-homelessness MEH domains, particularly substance abuse and street culture activities. This group was overwhelmingly male (84%) and mainly aged over 35. Notably, and in line with the regression analysis above, a disproportionate

number of Cluster 1 cases had migrated to the UK as adults (35%) and a majority (53%) were located in Westminster.

Cluster 2: 'Homelessness and mental health' This cluster accounted for over one quarter of the MEH population (28%), and its members displayed moderate complexity (9 experiences on average). A key feature of Cluster 2 cases was experiences associated with mental health problems: 86% reported experience of anxiety or depression and 51% had attempted suicide. Supporting previous evidence of a link between mental health issues and women's experience of homelessness, Cluster 2 was disproportionately female (39%).

Cluster 3: 'Homelessness, mental health and victimisation' This was a smaller group (9% of the MEH population), which may be viewed as a much more complex and severe version of Cluster 2 (15 experiences on average). Mental ill health was a defining characteristic: experience of anxiety or depression was reported by 100%, suicide attempts by 91%, being admitted to hospital with a mental health problem by 89%, and 75% had self-harmed. Cluster 3 members had also experienced exceptionally high levels of victimisation: 71% had been a victim of violent crime, and 40% had been a victim of sexual assault as an adult. Nearly half (48%) had been in local authority care as a child. This group was rather younger than the MEH population average.

Cluster 4: 'Homelessness and street drinking' This was also a smaller group (14% of the MEH population), and comprised a moderately complex set of cases (11 experiences on average). The defining experience of this group was street drinking (100%), with extremely high levels of problematic alcohol use (96%) and rough sleeping (98%) also reported. Other indicators of street culture activities were also common: 56% had begged and 47% had engaged in survival shoplifting. Divorce or separation was widespread in this group (65%). Cluster 4 members tended to be older (84% were over 35 years old), almost all were male (98%).

Cluster 5: 'Homelessness, hard drugs and high complexity' This cluster accounted for one quarter of the MEH sample (25%), and was the most complex (16 experiences on average). The defining experience was use of hard drugs (100%), with very high scores generally on the substance misuse and street culture domains. Although involvement in survival sex work was uncommon across the whole sample (at 10%), 21% of this group reported this experience (almost all of them women). Anxiety/ depression was almost universally experienced (95%), and rates of attempted suicide and self-harm were also high (56% and 47% respectively). Experience of prison was very prevalent (77%), with a strong theme of violence as both victim (56%) and perpetrator (51%). Cluster 5 members tended to be in the middle age range; most were in their 30s.

Sequencing of MEH experiences

We started the sequencing analysis by examining the median age of *first* occurrence of each MEH-relevant experience, as reported by affected individuals (see Table 3 overleaf)[4].

As Table 3 indicates, leaving home or care, and first experiences of substance misuse, tended to occur in relevant individuals' mid-to-late teens, as did survival sex work (for the minority who reported this experience). There was then a clutch of experiences that, on average, first occurred in the very early 20s: 'sofa-surfing', 'survival' shoplifting, being a victim of violent crime, prison, anxiety and depression, and injecting drug use. With the exception of 'sofa-surfing', homelessness experiences tended to be reported as having first happened to MEH service users in their mid-to-late

[4] No data is available on the age of first occurrence for the following experiences: being charged with a violent criminal offence; being a victim of sexual assault as an adult; having attempted suicide; and having engaged in deliberate self-harm. This is because these experiences were asked about in the self-completion section of the questionnaire where, in the interests of brevity, this information was not sought (except with regards to survival sex work).

20s. This was also the case with begging, being admitted to hospital with a mental health problem, and adverse life events including redundancy, eviction and bankruptcy. Divorce, repossession and (especially) death of a partner tended to happen at a higher median age.

Table 3: Median age of first occurrence

Experience	Percent	Median Age
Used solvents, gas or glue	23%	15
Left local authority care	16%	17
Thrown out by parents/carers	36%	17
Had sex or engaged in sex act in exchange for money, drugs, etc.	10%	17
Involved in street drinking	53%	18
Used hard drugs	44%	19
Had a period in life when had six or more alcoholic drinks on a daily basis	63%	20
Stayed with friends or relatives because had no home of own	77%	20
Shoplifted because needed things like food, drugs, alcohol or money for somewhere to stay	38%	20
Were a victim of violent crime (including domestic violence)	43%	20
Went to prison	46%	21
Had a period in life when very anxious or depressed	79%	22
Injected drugs	27%	22
Slept rough	77%	26
Admitted to hospital because of a mental health issue	29%	26
Made redundant	23%	26
Applied to the council as homeless	72%	27
Stayed at a hostel, foyer, refuge, night shelter or B&B hotel	84%	28
Begged (that is, asked passers-by for money in the street or another public place)	32%	28
Evicted from a rented property	25%	28
Experienced bankruptcy	6%	29
Divorced or separated	44%	32
Home was repossessed	6%	34
A long-term partner died	10%	43
Base	**452**	**-**

Source: Extended Interview Survey, 2010.

The order in which experiences occurred was then examined more rigorously by focusing on the actual sequential ranking of experiences within individual MEH cases[5]. The average sequential ranking used here controlled for variations in the number of MEH-relevant experiences reported by service users. This rank order pattern broadly reflected that suggested by the median age analysis, and across the MEH population as a whole, four broad phases were identified:

Phase 1 - Substance misuse: The experiences which tended to happen earliest, if they happened at all, were: abusing solvents, glue or gas; leaving home or care; using hard drugs; developing a problematic relationship with alcohol; and/or street drinking.

Phase 2 – Transition to street lifestyles: There was then a group of experiences that, if they occurred, tended to do so in the early-middle part of individual MEH sequences. These included: becoming anxious or depressed; survival shoplifting; engagement in survival sex work; being the

[5] Leaving care and engagement in survival sex work – while included in the age-based analysis – cannot be included in this rank order analysis as they were asked about in different parts of the questionnaire.

victim of a violent crime; sofa-surfing; and spending time in prison. These experiences seem indicative of deepening problems bringing people closer to extreme exclusion and street lifestyles. Also featuring in this early-middle ranked set of experiences was one adverse life event: being made redundant.

Phase 3 – Confirmed street lifestyle: Next, there was a set of experiences which typically occurred in the middle-late phase of individual MEH sequences, and seemed to confirm a transition to street lifestyles. These included: sleeping rough; begging; and injecting drug use. Being admitted to hospital with a mental health issue also tended to first occur in this phase, as did two of the specified adverse life events: becoming bankrupt and getting divorced.

Phase 4 – 'Official' homelessness: Finally, there was a set of experiences which tended to happen late in individual MEH sequences. These included the more 'official' forms of homelessness (applying to the council as homeless, and staying in hostels or other temporary accommodation) and the remaining adverse life events (being evicted or repossessed, and the death of a partner).

Another important finding was that sequencing within each of the five experiential clusters tended to mirror this overall temporal pattern. In other words, *if* an event occurred to an individual MEH service user, it tended to occur at approximately the same point in their MEH sequence regardless of which cluster they were in, even though the chances of it having happened at all varied significantly between clusters.

Childhood experiences of disadvantage and trauma

Table 4 below indicates that most MEH service users had experienced troubled childhoods marred by school and/or family problems, with many also reporting traumatic experiences such as sexual or physical abuse, homelessness or neglect.

Table 4: Experiences in childhood (under 16 years old)

Experience	Percent
Truanted from school a lot	50%
Suspended, excluded or expelled from school at least once	36%
Ran away from home and stayed away for at least one night	34%
Didn't get along with parent(s)/step-parent/carer(s)	29%
Violence between parents/carers	27%
Parent(s)/step-parent/carer(s) had a drug or alcohol problem	24%
Sexually abused	23%
Badly bullied by other children	22%
Physically abused at home	22%
Brought up in workless household	21%
Family was homeless	16%
Spent time in local authority care	16%
There was sometimes not enough to eat at home	15%
Neglected	15%
Parent(s)/step-parent/carer(s) had a mental health problem	15%
Base	452

Source: Extended Interview Survey, 2010.

In all, 78% of MEH service users reported at least one of the experiences in Table 4. These difficult childhood experiences were somewhat less prevalent amongst MEH service users who had migrated to the UK as an adult: 57% of migrant service users reported at least one of these experiences, as compared with 85% of non-migrant service users. There was a strong age gradient, whereby many of these experiences were most commonly reported by those under 25, and least commonly reported by over 50s. There was less distinction by gender, though females were most likely to report not getting along with their parents/carers and to have had parents with mental health problems. Experience of childhood sexual abuse was also concentrated amongst female interviewees.

Policy and Practice Implications

A number of implications for policy and practice were highlighted by the study:

- The evidence strongly supports the argument that there is a very high degree of intersection between deeply socially excluded groups. There is a pressing need to coordinate responses across all aspects of these people's lives, rather than 'view' them through a series of separate 'professional lenses'.
- Service providers working with people experiencing MEH should be alert to the probability that most of their service users will have experienced a range of forms of trauma in childhood, and a large proportion may have exhibited extreme forms of distress in adulthood (such as attempted suicide or self-harm) without the agencies necessarily being aware of this. The development of 'psychologically-informed' service environments should be a priority.
- Service providers may wish to take into account the 'clusters' of experiences described above in designing tailored services for different groups within the MEH population, though it must always be borne in mind that such broad categorisations are not a substitute for individual needs assessments.
- 'Visible' forms of homelessness – including applying to the council as homeless and staying in hostels or other forms of homeless accommodation – are typically rather 'late' signs of MEH, and preventative interventions should focus on earlier signs of distress wherever possible.
- Schools, drugs and alcohol treatment services, and the criminal justice system, are likely to come into contact with people vulnerable to MEH before housing and homelessness agencies do so, and must therefore be central to prevention efforts.
- While the policy emphasis – and public sympathy – often focuses on younger and older homeless people, and on women who are homeless, it may be argued that there is a 'forgotten middle' of men in their 30s who often face the most extreme forms of MEH.
- The profile and experiences of migrants facing MEH in the UK seems to differ in quite fundamental ways from those of the indigenous MEH population, and they require bespoke services tailored to their specific needs.

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About the Study

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The study was conducted by Professor Suzanne Fitzpatrick and Dr Sarah Johnsen at the Institute for Housing, Urban and Real Estate Research (IHURER), Heriot-Watt University, with input also from Professor Glen Bramley (Heriot-Watt University), Professor Michael White (Nottingham Trent University), and Nicholas Pleace (University of York). Dr Caroline Brown (Heriot-Watt University) helped to prepare a series of Briefing Papers on the study for publication. The study fieldwork was conducted in 2010 in collaboration with TNS-BMRB and a wide range of voluntary sector partners, including seven 'local co-ordinators' and 39 low-threshold services which participated in the research. We were also supported throughout this work by our Project Advisory Group and the Coordinator of the MEH Programme, Theresa McDonagh.

All views and any errors contained in this Briefing Paper are the responsibility of the authors alone.

More information on the study and further Briefing Papers can be found at:
http://www.sbe.hw.ac.uk/research/ihurer/homelessness-social-exclusion/**multiple-exclusion-homelessness**.htm or http://tinyurl.com/8xuh74q

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